		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0018143

Facility Name: Fair Havens Christian Home

Address: 1790 South Fairview Avenue (Number) Decatur (City) 62521 (Zip Code)

County: Macon

Telephone Number: 217-429-2551 **Fax #** ( )

IDPA ID Number: 23-7437316001

Date of Initial License for Current Owners: 1975

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(C)3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 1999 to June 30, 2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Mark Havrilka
(Title) Chief Financial Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke, LLP 600 East Adams Springfield, IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	161	Skilled (SNF)	161	58,926	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	161	TOTALS	161	58,926	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,302	19,231	274	40,807	8
9	SNF/PED					9
10	ICF	7,860	7,758		15,618	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,162	26,989	274	56,425	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.76%

D. How many bed-hold days during this year were paid by Public Aid?
194 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 12/12/75

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 5 and days of care provided 274

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/00 Fiscal Year: 06/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Fair Havens Christian Home # 0018143 **Report Period Beginning:** July 1, 1999 **Ending:** June 30, 2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	214,534	29,952	12,072	256,558		256,558		256,558			1
2	Food Purchase		289,416		289,416		289,416	(258)	289,158			2
3	Housekeeping	197,930	23,654		221,584		221,584		221,584			3
4	Laundry	51,414	20,792		72,206		72,206		72,206			4
5	Heat and Other Utilities			131,894	131,894		131,894	(9,661)	122,233			5
6	Maintenance	83,898	19,684	51,091	154,673		154,673	7,872	162,545			6
7	Other (specify):*											7
8	**TOTAL General Services**	547,776	383,498	195,057	1,126,331		1,126,331	(2,047)	1,124,284			8
	B. Health Care and Programs											
9	Medical Director			13,050	13,050		13,050		13,050			9
10	Nursing and Medical Records	1,837,100	87,015	5,511	1,929,626		1,929,626		1,929,626			10
10a	Therapy			10,854	10,854		10,854		10,854			10a
11	Activities	17,024		1,960	18,984		18,984	(702)	18,282			11
12	Social Services	129,059	5,017		134,076		134,076	5	134,081			12
13	Nurse Aide Training											13
14	Program Transportation		7,861		7,861		7,861		7,861			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,983,183	99,893	31,375	2,114,451		2,114,451	(697)	2,113,754			16
	C. General Administration											
17	Administrative	72,463	1,681	225,151	299,295		299,295	(168,193)	131,102			17
18	Directors Fees											18
19	Professional Services			8,245	8,245		8,245	22,370	30,615			19
20	Dues, Fees, Subscriptions & Promotions			24,588	24,588		24,588	(8,391)	16,197			20
21	Clerical & General Office Expenses	122,201	4,102	39,635	165,938		165,938	18,688	184,626			21
22	Employee Benefits & Payroll Taxes			376,424	376,424		376,424	4,230	380,654			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,877	8,877		8,877	3,011	11,888			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			14,050	14,050		14,050	1,653	15,703			26
27	Other (specify):*											27
28	**TOTAL General Administration**	194,664	5,783	696,970	897,417		897,417	(126,632)	770,785			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,725,623	489,174	923,402	4,138,199		4,138,199	(129,376)	4,008,823			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Fair Havens Christian Home #0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			188,581	188,581		188,581	31,880	220,461			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			45,330	45,330		45,330	(17,316)	28,014			32
33	Real Estate Taxes			285	285		285	(285)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			234,196	234,196		234,196	14,279	248,475			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			2,187	2,187		2,187		2,187			39
40	Barber and Beauty Shops	19,280	926		20,206		20,206		20,206			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			88,390	88,390		88,390		88,390			42
43	Other (specify):* Apt/Congregate			358,959	358,959		358,959		358,959			43
44	**TOTAL Special Cost Centers**	19,280	926	449,536	469,742		469,742		469,742			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,744,903	490,100	1,607,134	4,842,137		4,842,137	(115,097)	4,727,040			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(258)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,475)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	22,841	30		9
10	Interest and Other Investment Income	(12,580)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,670)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(4,736)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(285)	33		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,747)	21		24
25	Fund Raising, Advertising and Promotional	(9,572)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		21		28
29	Other-Attach Schedule Gain/Loss, Vending Mach Rev	(960)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (26,442)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(88,655)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (88,655)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (115,097)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

STATE OF ILLINOIS

Fair Havens Christian Home

ID# 0018143

Report Period Beginning: July 1, 1999

Ending: June 30, 2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Machine	$ (702)	11	1
2	Gain/Loss Sale of Investment	(263)	17	2
3	Activity revenue	5	12	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(960)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fair Havens Christian Home **#** 0018143 **Report Period Beginning:** July 1, 1999 **Ending:** June 30, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(258)	0	0	0	0	0	0	0	0	0	0	(258)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(10,475)	814	0	0	0	0	0	0	0	0	0	(9,661)	5
6	Maintenance	0	7,872	0	0	0	0	0	0	0	0	0	7,872	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,733)	8,686	0	0	0	0	0	0	0	0	0	(2,047)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(702)	0	0	0	0	0	0	0	0	0	0	(702)	11
12	Social Services	5	0	0	0	0	0	0	0	0	0	0	5	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(697)	0	0	0	0	0	0	0	0	0	0	(697)	16
	C. General Administration													
17	Administrative	(263)	(167,930)	0	0	0	0	0	0	0	0	0	(168,193)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	22,370	0	0	0	0	0	0	0	0	0	22,370	19
20	Fees, Subscriptions & Promotions	(9,572)	1,181	0	0	0	0	0	0	0	0	0	(8,391)	20
21	Clerical & General Office Expenses	(10,417)	29,105	0	0	0	0	0	0	0	0	0	18,688	21
22	Employee Benefits & Payroll Taxes	0	4,230	0	0	0	0	0	0	0	0	0	4,230	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,011	0	0	0	0	0	0	0	0	0	3,011	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,653	0	0	0	0	0	0	0	0	0	1,653	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(20,252)	(106,380)	0	0	0	0	0	0	0	0	0	(126,632)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(31,682)	(97,694)	0	0	0	0	0	0	0	0	0	(129,376)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fair Havens Christian Home # 0018143 **Report Period Beginning:** July 1, 1999 **Ending:** June 30, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	22,841	9,039	0	0	0	0	0	0	0	0	0	31,880	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(17,316)	0	0	0	0	0	0	0	0	0	0	(17,316)	32
33	Real Estate Taxes	(285)	0	0	0	0	0	0	0	0	0	0	(285)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	5,240	9,039	0	0	0	0	0	0	0	0	0	14,279	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(26,442)	(88,655)	0	0	0	0	0	0	0	0	0	(115,097)	45

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administration	$ 209,100	Christian Homes, Inc.	100.00%	$ 41,170	$ (167,930)	1
2	V								2
3	V	5	Heat & Utilities				814	814	3
4	V	6	Maintenance				7,872	7,872	4
5	V	18	Directors						5
6	V	19	Professional Services Other				22,370	22,370	6
7	V	20	Fees, Subscriptions, & Promo				1,181	1,181	7
8	V	21	Clerical & General Ofc				29,105	29,105	8
9	V	22	Employee Benefits	9,072			13,302	4,230	9
10	V	23	Inservice Training/Education						10
11	V	24	Travel/Seminar				3,011	3,011	11
12	V	26	Insurance-Prop/Liab/& Malpract				1,653	1,653	12
13	V	30	Depreciation				9,039	9,039	13
14	Total			$ 218,172			$ 129,517	$ * (88,655)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: ne 30, 2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	1993-A General Rev Bond		x	Debt Restructure	$3,060.00	01/01/93	$ 420,000	$ 372,435	01/01/18	0.0750	$ 28,098	1
2	Reilly Mortgage		x	Building & Equipment	$16,312.00	08/01/74	2,150,100	159,920	05/01/01	0.0775	12,174	2
3												3
4												4
5												5
	Working Capital											
6												6
7	CHI Bond Fund	x		Nursing Home	$5,000.00	04/01/00	60,000	5,321		0.0850	322	7
8												8
9	TOTAL Facility Related				$24,372.00		$ 2,630,100	$ 537,676			$ 40,594	9
	B. Non-Facility Related*											
10	CHI Bond Fund	x		Apartments	$5,500.00	10-01-96	671,629	50,817		0.0850	818	10
11	Steve Horve Builders, Inc.			Option fees for Forysth Land		03/27/00	325,000	325,000			3,918	11
12												12
13												13
14	TOTAL Non-Facility Related				$5,500.00		$ 996,629	$ 375,817			$ 4,736	14
15	TOTALS (line 9+line14)						$ 3,626,729	$ 913,493			$ 45,330	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,500 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	57,000	1972	$ 54,638	1
2	Home Office			7,753	2
3	TOTALS	57,000		$ 62,391	3

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155		1977	1977	$ 2,180,767	$ 51,312	40	$ 54,519	$ 3,207	$ 1,553,571	4
5					384,841		20	19,242	19,242	194,344	5
6	6		1983	1983	109,815	2,745	35	3,137	392	51,776	6
7											7
8	Home Office				55,321	1,807		1,807		24,018	8
	Improvement Type**										
9	Land Improvement			1975	541		20			541	9
10	Wall Guards			1979	485		15			485	10
11	Garage			1979	4,167	139	30	139		2,988	11
12	Drain Pipes			1980	541	8	20	8		541	12
13	Landscaping			1980	4,884	244	20	244		4,880	13
14	Heat Tapes			1980	2,151	18	15	18		2,151	14
15	Parking Lot			1980	22,800	126	15	126		22,800	15
16	Drainage Work			1981	1,577	79	20	79		1,560	16
17	Heating System			1981	14,100		10			14,100	17
18	Wall Coverings			1981	1,277		10			1,277	18
19	Heating Control System			1982	20,503	1,025	20	1,025		18,706	19
20	Fence Guard Rail			1982	2,027		10			2,027	20
21	Electric Work			1982	2,133	2	10	2		2,133	21
22	Fire Alarm			1982	858	43	20	43		760	22
23	New Office			1983	2,700	90	30	90		1,575	23
24	Wallcovering			1983	2,301		10			2,301	24
25	Tiling			1983	615		10			615	25
26	Shrubs			1984	180	1	10	1		180	26
27	Office Remodel			1984	2,594	86	30	86		1,412	27
28	Window Installation			1984	2,083	3	10	3		2,083	28
29	Down Spouts			1984	639		10			639	29
30	Floor Covering			1984	550	1	10	1		550	30
31	Shrubs & Trees			1984	3,346	24	10	24		3,346	31
32	Roof Work			1984	163,201	4,080	40	4,080		70,803	32
33	Electric Door			1984	10,229	85	10	85		10,229	33
34	Floor Covering			1985	3,457	35	10	35		3,457	34
35	Page 12D(2) Totals				53,871	7,380		7,380		7,820	35
36	TOTAL (lines 4 thru 35)				$ 3,054,554	$ 69,333		$ 92,174	$ 22,841	$ 2,003,668	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fire Alarm			1985	1,705	85	20	85		1,311	9
10	Windows			1985	3,558	30	10	30		3,558	10
11	Parking Lot			1985	22,591	1,506	15	1,506		22,214	11
12	Roof			1985	29,843	1,990	15	1,990		29,187	12
13	Skylite (Deleted 06/30/91)			1985							13
14	Door Kick Guards			1985	419		10			419	14
15	Landscaping			1986	270		10			270	15
16	Electrical Recepticals			1986	2,419	121	20	121		1,714	16
17	Landscaping			1986	2,290	115	20	115		1,572	17
18	Landscaping			1986	4,318	216	20	216		2,970	18
19	Wiring			1987	7,530	376	20	376		5,043	19
20	Ceiling			1987	300		10			300	20
21	Sidewalk			1987	3,493	175	20	175		2,290	21
22	Rewiring			1987	1,600	80	20	80		1,013	22
23	Carpeting			1988							23
24	Wallpapering			1989	505		5			505	24
25	Signs			1989	1,224		5			1,224	25
26	Landscaping			1989	2,726	136	20	136		1,507	26
27	Soap Dispensers			1989	672	2	5	2		672	27
28	Compressor Freezer			1989	810	1	5	1		810	28
29	Storage Cabinet			1990	1,100	73	15	73		760	29
30	Tempering Valve			1990	3,199	213	15	213		2,201	30
31	Landscaping			1990	407	20	20	20		202	31
32	Remodel Dining Room			1991	4,708	235	20	235		2,350	32
33	Install Panic Bars			1991	780	78	10	78		722	33
34	Install Window			1991	988	66	15	66		611	34
35	Flooring			1991	4,380		5			4,380	35
36	TOTAL (lines 4 thru 35)				$ 101,835	$ 5,518		$ 5,518	$	$ 87,805	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roof Repair			1991	29,860	1,991	15	1,991		18,251	9
10	A/C Compressor			1991	1,076	1	5	1		1,076	10
11	Touchpads Exit Door			1991	792	79	10	79		698	11
12	Stainless Steel Sink			1991	1,630	163	10	163		1,426	12
13	Walkway Canopy			1991	4,412	221	20	221		1,934	13
14	Showers			1991	3,669	367	10	367		3,150	14
15	Remodel Office			1992	8,715	436	20	436		3,524	15
16	Fence			1991	1,294	65	20	65		563	16
17	Door Locks & Magnets			1992	2,540	254	10	254		1,990	17
18	Interior Landscaping			1992	3,839	384	10	384		2,912	18
19	Handrails			1993	12,800	853	15	853		6,398	19
20	Wall Cabinets			1993	2,564	171	15	171		1,254	20
21	Bathroom Remodel			1993	12,341	617	20	617		4,422	21
22	Nurses Station Desks			1994	18,588	929	20	929		5,961	22
23	Alarm/Auto Door			1994	4,257	426	10	426		2,662	23
24	Cabinets			1994	1,480	99	15	99		602	24
25	Seal/Stripe Parking Lot			1994	5,010		3			5,010	25
26	Carpeting in Office			1993	979	19	5	19		979	26
27	Gas Rooftop Piping			1994	4,905	245	20	245		1,409	27
28	Heating & A/C Unit			1994	5,565	278	20	278		1,599	28
29	Remodel Garage			1995	3,704	370	10	370		2,004	29
30	Remodel Nurses Station			1995	15,656	1,566	10	1,566		8,091	30
31	Thru Wall A/C Unit			1995	3,120	390	8	390		2,015	31
32	Flourescent Light Covers			1995	1,218	222	5	222		1,218	32
33	Roof Work			1995	52,000	3,467	15	3,467		17,624	33
34	Service Sink			1995	1,003	100	10	100		517	34
35	Wallcovering Dayroom Station 1			1995	2,573	515	5	515		2,532	35
36	TOTAL (lines 4 thru 35)				$ 205,590	$ 14,228		$ 14,228	$	$ 99,821	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Baseboard Pipe			1995	2,978	596	5	596		2,881	9
10	Thru Wall A/C			1995	3,120	390	8	390		1,885	10
11	Shower Valves			1995	1,807	181	10	181		860	11
12	Resident Room Signs			1995	1,516	303	5	303		1,439	12
13	Utility Room Cabinet			1995	599	40	15	40		190	13
14	Magnets for Fire Doors			1995	795	159	5	159		755	14
15	Fire Door Closers			1995	1,200	240	5	240		1,120	15
16	Install 2 Deck Faucets			1995	826	165	5	165		770	16
17	Nurse Call System			1995	925	93	10	93		434	17
18	Install Sprinkler Laundry			1995	557	56	10	56		261	18
19	Electronic Thermostats			1995	733	147	5	147		686	19
20	Breakers 6/receptacles			1995	883	177	5	177		826	20
21	Remodel Main Lobby			1995	4,569	914	5	914		4,189	21
22	Remodel Station			1996	12,472	2,494	5	2,494		11,223	22
23	Rooftop Heating/AC Dining Room			1996	11,975	1,198	10	1,198		5,391	23
24	Floorwork Dayroom			1996	2,247	449	5	449		1,983	24
25	Heating & A/C Station			1996	7,550	755	10	755		3,335	25
26	Floorwork Dining Room			1996	6,974	697	10	697		3,078	26
27	Honeywell Receiver			1996							27
28	Water Softener			1996	10,580	1,058	10	1,058		4,408	28
29	Water Heaters			1996	39,422	3,942	10	3,942		16,425	29
30	2 Sprinkler Cooler			1996	772	154	5	154		565	30
31	Remodel Station			1996	8,261	1,652	5	1,652		5,920	31
32	Shelving Linen Closet			1997	540	108	5	108		351	32
33	Gas Piping in Laundry			1997	1,155	116	10	116		377	33
34	Heating & A/C Rooftop			1997	8,950	895	10	895		2,834	34
35	Floorwork Station 4 Hall			1997	10,153	1,015	10	1,015		3,130	35
36	TOTAL (lines 4 thru 35)				$ 141,559	$ 17,994		$ 17,994	$	$ 75,316	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Dining Room Announcement			1997	549	110	5	110		339	9
10	Above Ground Diesel Tank			1992	9,876	494	20	494		3,967	10
11	Replace Concrete Entrance			1995	5,159	516	10	516		2,451	11
12	Replace Concrete Walk			1995	1,725	173	10	173		822	12
13	Remodel Beauty Shop			1997	1,669	334	5	334		974	13
14	Energy Management System			1997	14,637	732	20	732		1,952	14
15	Remove Slab Freezer Area			1997	2,860	953	3	953		2,462	15
16	Floor Tile - Station 4 Rooms			1998	7,500	1,500	5	1,500		3,500	16
17	Station 3 Carrier FR A/C			1998	7,597	760	10	760		1,583	17
18	Carpet Chapel/Lobby/Office			1998	2,483	497	5	497		1,033	18
19	Wood Cove BS/60 Rooms			1998	9,412	1,882	5	1,882		3,921	19
20	Alarm System			1998	11,937	1,194	10	1,194		2,482	20
21	Wallpaper Station 1 & 2 Rooms			1998	38,443	7,689	5	7,689		15,992	21
22	Seal/Stripe Parking Lot			1998	7,790	2,597	3	2,597		5,410	22
23	Ventilation - Electric Room			1999	1,875	375	5	375		656	23
24	48-Safety Grab Bars			1999	864	173	5	173		288	24
25	161-Glass/Resident Walls			1999	2,256	226	10	226		377	25
26	Install Grab Bars			1999	2,401	240	10	240		360	26
27	Install 24V Door Closer			1999	1,189	238	5	238		357	27
28	Water Heater - Station 3			1999	655	131	5	131		164	28
29	Remodel Station 4			1999	26,585	1,772	15	1,772		2,207	29
30	Back Door Alarm Pad			1999	2,874	287	10	287		359	30
31	Nurse Call Units			1999	598	60	10	60		70	31
32	Front Countertop			1999	881	59	15	59		69	32
33	Mixing Valve/Install			1999	524	105	5	105		114	33
34	Pella Storm Window - 13			1999	527	105	5	105		114	34
35	Smoke Detectors-4			1999	553	55	10	55		60	35
36	TOTAL (lines 4 thru 35)				$ 163,419	$ 23,257		$ 23,257	$	$ 52,083	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carrier Rooftop Unit			1999	6,779	678	10	678		734	9
10	Wallpaper Station 3 Rooms			1999	23,706	4,741	5	4,741		5,125	10
11	Compressors (3)			2000	2,239	684	3	684		684	11
12	Cove Base-Station 3			2000	1,408	235	5	235		235	12
13	Baseboard			2000	1,371	206	5	206		206	13
14	Light Fixtures (2 Day Room)			2000	947	71	10	71		71	14
15	Floor Tile-Hall/Bath/Kitchen			2000	3,079	411	5	411		411	15
16	Panic			2000	1,059	88	5	88		88	16
17	Security Locks-Front Door			2000	900	45	5	45		45	17
18	Exhaust Fans (6)			2000	702	35	5	35		35	18
19	Carrier Rooftop Unit			2000	7,637	127	10	127		127	19
20	Ceiling Grid Covers			2000	1,418	15	8	15		15	20
21	Compressor Room 101			2000	1,131	6	15	6		6	21
22	8 x 12 Storage Shed			2000	1,495	38	10	38		38	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 53,871	$ 7,380		$ 7,380	$	$ 7,820	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 511,846	$ 55,382	$ 55,382	$		$ 313,317	37
38	Current Year Purchases	71,564	4,676	4,676			4,676	38
39	Fully Depreciated Assets	334,317					307,499	39
40	Home Office	48,287	4,984	4,984			39,262	40
41	TOTALS	$ 966,014	$ 65,042	$ 65,042	$		$ 664,754	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Transportation	1986 Wayne Bus	1987	$ 30,743	$	$	$	8	$ 30,743	42
43	Patient Transportation	Van	1988	3,317				3	3,317	43
44	Home Office			10,515	2,248	2,248			3,241	44
45										45
46	TOTALS			$ 44,575	$ 2,248	$ 2,248	$		$ 37,301	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 4,739,937	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 197,620	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 220,461	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 22,841	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 3,020,748	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Land/Land Improvements	$ 1,004,499	$ 39,316	$ 111,345	52
53	Duplex/Equipment	6,679,448	193,718	699,206	53
54	Forysth Land Development	175,712			54
55	Congregate/Assisted Living	121,693			55
56	HPCV Duplex				56
57	TOTALS	$ 7,981,352	$ 233,034	$ 810,551	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaprer is not applicable.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 414,423	$	1
2	Cash-Patient Deposits	20,471		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 16,913)	355,781		3
4	Supply Inventory (priced at FIFO)	35,367		4
5	Short-Term Investments	110,457		5
6	Prepaid Insurance	17,488		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Int & Misc Receivable	16,423		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 970,409	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	414,453		13
14	Buildings, at Historical Cost	9,900,173		14
15	Leasehold Improvements, at Historical Cost	742,327		15
16	Equipment, at Historical Cost	1,241,678		16
17	Accumulated Depreciation (book methods)	(3,259,375)		17
18	Deferred Charges	17,547		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	633,879		21
22	Other Long-Term Assets (spc CIP	300,578		22
23	Other(specify): FNMA Reserve Acct	205,013		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,196,272	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,166,681	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 75,644	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,471		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	181,961		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	14,020		32
33	Accrued Interest Payable	664		33
34	Deferred Compensation	1,104,743		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,397,503	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	537,676		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Apt/Congregate Life Right	4,115,327		43
44	Security Deposit Payable	990		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,653,993	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,051,496	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,115,185	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,166,681	$	48

***(See instructions.)**

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,633,507	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,633,507	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	481,678	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 481,678	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,115,185	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,803,382	1
2	Discounts and Allowances for all Levels	(987,189)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,816,193	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	426	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 426	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	702	12
13	Barber and Beauty Care	23,202	13
14	Non-Patient Meals	258	14
15	Telephone, Television and Radio	10,475	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,233	19
20	Radiology and X-Ray	2,637	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 38,506	23
	D. Non-Operating Revenue		
24	Contributions	30,771	24
25	Interest and Other Investment Income***	56,308	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 87,079	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Residential/Congregate**	383,157	28
28a	**Unrealized G/(L) on Sale of Equip & Investments**	(1,546)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 381,611	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,323,815	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,126,331	31
32	Health Care	2,114,451	32
33	General Administration	897,417	33
	B. Capital Expense		
34	Ownership	234,196	34
	C. Ancillary Expense		
35	Special Cost Centers	381,352	35
36	Provider Participation Fee	88,390	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,842,137	40
41	**Income before Income Taxes (line 30 minus line 40)****	481,678	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 481,678	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,718	1,895	$ 40,586	$ 21.42	1
2	Assistant Director of Nursing	1,706	1,882	38,936	20.69	2
3	Registered Nurses	12,193	13,448	277,804	20.66	3
4	Licensed Practical Nurses	26,214	28,911	373,475	12.92	4
5	Nurse Aides & Orderlies	110,792	122,191	1,070,190	8.76	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,657	1,827	17,024	9.32	9
10	Activity Assistants					10
11	Social Service Workers	11,432	12,608	129,059	10.24	11
12	Dietician					12
13	Food Service Supervisor	1,671	1,843	18,390	9.98	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,145	26,629	196,144	7.37	15
16	Dishwashers					16
17	Maintenance Workers	6,342	6,995	83,898	11.99	17
18	Housekeepers	22,577	24,900	197,930	7.95	18
19	Laundry	5,079	5,602	51,414	9.18	19
20	Administrator	2,797	3,085	72,463	23.49	20
21	Assistant Administrator					21
22	Other Administrative	4,781	5,273	68,503	12.99	22
23	Office Manager	1,679	1,852	28,313	15.29	23
24	Clerical	3,046	3,359	25,385	7.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	3,550	3,915	36,109	9.22	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	1,935	2,134	19,280	9.03	33
34	TOTAL (lines 1 - 33)	243,314	268,349	$ 2,744,903 *	$ 10.23	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	289	$ 12,072	1.1	35
36	Medical Director	5	12,000	9.3	36
37	Medical Records Consultant	24	1,050	9.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		900	10.3	39
40	Physical Therapy Consultant	137	6,502	10a.3	40
41	Occupational Therapy Consultant	19	944	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	27	1,988	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant	104	7,861	12.1	45
46	Other(specify) Dental	11	550	10.3	46
47	Utilization Review Committee	16	1,420	10.3	47
48					48
49	TOTAL (lines 35 - 48)	632	$ 45,287		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael J. Weiss	Administrator	0	$ 34,710
Blair Wagner	Asst. Administrator	0	37,753
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 72,463

B. Administrative - Other

Description	Amount
Management Fees	$ 209,100
Marketing Fees	16,051
TOTAL (agree to Schedule V, line 17, col. 3)	$ 225,151
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Booth & Antoline	Professional Services	$ 272
Ed Drobisch & Co.	Real Estate	225
Christian Homes	Medicare Recapture	7,442
Christian Homes	Telephone Support	245
McNamar, Fearnow & McSharrar	Professional Services	61
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 8,245

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 75,180
Unemployment Compensation Insurance	9,072
FICA Taxes	204,814
Employee Health Insurance	62,700
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Related Party Adjustment	(9,072)
Employee Expense	11,339
Employee Physicals	3,725
Worker's Comp Medical Expense	9,594
Home Office Allocation	13,302
TOTAL (agree to Schedule V, line 22, col.8)	$ 380,654

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 125
Advertising: Employee Recruitment	795
Health Care Worker Background Check	
(Indicate # of checks performed)	
Subscriptions	927
Renewals	170
Membership/Dues	9,836
Fees/Updates	3,148
Miscellaneous	15
Home Office Allocation	1,181
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,197

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,307
Seminar Expense	5,632
Other Costs	(62)
Home Office Allocation	3,011
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,888

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 1999 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network -$ 7,400.43**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **n/a**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,702** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **88,390**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **n/a** Has any meal income been offset against related costs? **No** Indicate the amount. $ **n/a**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **To be supplied when completed.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.